August 23, 2002

TO: NAME
STREET ADDRESS
CITY, STATE ZIP CODE

FROM: Santosh Shaunak, Acting Director
Office of Newborn Screening

RE: Request to Destroy Residual Newborn Screening Specimen

This information is provided in response to your request for destruction of residual dried blood specimens currently stored at the Washington State Newborn Screening Laboratory. We will honor such requests when made by a parent or legal guardian of a minor patient or the patient, if over 18 years of age. **Upon receipt of a completed copy of the enclosed request form and a photocopy (certified copy is not necessary) of the patient's birth certificate**, the Office of Newborn Screening will make a good faith effort to locate all specimens related to the patient within 60 days. For each specimen located we will:

- Photocopy the front and back of the blood spots.
- Separate the filter paper containing blood spots from the specimen card.
- Destroy the filter paper and blood spots by incineration.
- Notify you of all specimens located and destroyed, and the date destroyed.
- File the specimen card with the photocopy of the blood spots, your original written request and, a copy of our notification to you of our action.

Enclosed are forms and a self-addressed, postage-paid envelope for you to use when submitting your request. (You must use a separate form for each patient.) Also enclosed is a copy of our current policy related to this issue.

If you have questions or require additional information, please feel free to contact me at (206) 361-4985.

Request to Destroy Residual Newborn Screening Specimens

Patient's Name _____

Patient's Date of Birth _____

Your Name _____

Your Current Mailing Address:
Street _____
City, State, Zip Code _____

Your Relationship to Patient_____

I request that the identified patient's remaining Newborn Screening dried blood specimens stored by the Washington State Office of Newborn Screening be destroyed.

"I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct":

_____ _____
(Signature) *(Date)*

_____
(Place)

Return this form along with a photocopy (a certified copy is not necessary) of the patient's birth certificate to:

Director, Newborn Screening
1610 NE 150th Street
Shoreline, WA 98155